Maryland Medicaid's Maternal Opioid Misuse Model—Best Practices and Expectations for Case Management, Staffing and Workflow

Version 1.0 (25 January 2020)

Executive Summary

The purpose of this document is to outline the accepted case manager provider types, staffing related needs and expectations, as well as workflow to fulfill the case management aspect of the Maternal Opioid Misuse (MOM) model. This document is meant to be used as a resource for MCOs to refer to while finalizing their staffing plans and preparing for implementation. Additionally, the case management workflow section of this document provides a detailed overview of the associated tasks required at various points during a participant's engagement in the model to fulfill the requirements needed to receive $208 per member per month (PMPM) payments.

Background

The Maryland Department of Health (the Department) launched its MOM model in January 2020, with funding from the Center for Medicare and Medicaid Innovation (CMMI) and in collaboration with the Centers for Medicare and Medicaid Services (CMS). The MOM model focuses on improving care for pregnant and postpartum Medicaid beneficiaries diagnosed with opioid use disorder (OUD). Substance use is a leading cause of maternal death and has a significant impact on the approximately 1,500 infants born to Medicaid participants with OUD in Maryland per year. Maryland's MOM model addresses fragmentation in the care of pregnant and postpartum Medicaid participants with OUD through collaborative efforts with its managed care organizations (MCOs), improved data infrastructure and strengthened provider capacity in underserved areas of the state. The MOM model aims to increase utilization of physical and

behavioral health care services, such as medication for opioid misuse disorder (MOUD), as well as to address health-related social needs, for this population through enhanced MCO case management.

Best Practices

Case Management

The Substance Abuse and Mental Health Services Administration (SAMHSA) has described *case management* as a coordinated approach to the delivery of health and social services, linking clients with appropriate resources to address specific needs. SAMHSA notes that effective case management consists of the following set of functions: (1) assessment; (2) planning; (3) linkage; (4) monitoring; and, (5) advocacy.[1] Similarly, *case manager* has been defined as an individual responsible for executing case management activities, including assessment of needs, service planning, service plan implementation, service coordination, monitoring and follow-up, reassessment, case conferencing, crisis intervention, and case closure.[2]

Case Managers can serve as a single point of contact for participants who receive services from various entities. For the purposes of the Maryland MOM model, MCO-designated case managers will serve as the "quarterback of care," ensuring participants enrolled in the MOM model not only receive needed health care services but also gain access to and remain connected to appropriate social services in the community. The overarching goal of comprehensive and coordinated case management is to reduce barriers that impede access to and/or compliance with treatment. Research has shown that retention in Substance Use Disorder (SUD) treatment is more likely when other social needs are addressed concurrently.[3] Such needs include, but are not limited to: housing supports, food assistance, vocational services, educational resources, transportation, child care, legal assistance and peer support.[4]

Other *Best Practices* for case management through the MOM model involve:

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[1] Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 27. HHS Publication No. (SMA) 15-4215. Rockville, MD: Center for Substance Abuse Treatment, 2000. Retrieved from: https://store.samhsa.gov/system/files/sma15-4215.pdf

[2] New York State Department of Health AIDS Institute. Standards for HIV/AIDS Case Management. 2006. Retrieved from: https://www.health.ny.gov/diseases/aids/providers/standards/casemanagement/docs/casemanagementstandards.pdf

[3] Substance Abuse and Mental Health Services Administration. Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series, No. 51. HHS Publication No. (SMA) 13-4426. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009. Retrieved from: https://store.samhsa.gov/system/files/sma15-4426.pdf

[4] Center for Substance Abuse Treatment. Medication for Opioid Use Disorder. Treatment Improvement Protocol (TIP) Series No. 63. HHS Publication No. (SMA) 18-5063. Rockville, MD: Center for Substance Abuse Treatment, 2018. Retrieved from: https://medicine.yale.edu/edbup/quickstart/TIP_63_338482_42801_v1.pdf

- Developing and revisiting MOM care plans during face-to-face meetings[5] and negotiating between MOM model participants and case managers to encourage active participation and empowerment;
- Jointly developing measurable goals and activities—taking into consideration the participants' cognitive and physical abilities, available resources, support networks and motivations—that result in a more realistic, MOM model participant-specific care plan;
- Offering a copy of the MOM care plan to the participant, reinforcing participant ownership and involvement in the case management process;
- Documenting changes or updates to the MOM care plan as well as actual outcomes to track MOM model participant progress;
- Engaging family members and the participant's support network to assist in ensuring a MOM model participant receives needed service, including inclusion in the MOM care plan to carry out activities;
- Strengthening data-sharing and communication between MCOs and the Behavioral Health Administrative Services Organization (BH ASO); and
- Building relationships between MCOs, Local Health Departments (LHDs), and Local Behavioral Health Authorities (LBHAs) to leverage unique local opportunities and programs for MOM model participants.

Staffing

While MCOs must include one or more Medicaid-approved qualified provider type as the designated MOM model case manager(s) in their staffing model (see below for eligible provider types); MCOs may enlist lay health workers, such as community health workers (CHWs) and Certified Peer Recovery Specialists (CPRSs), to support engagement and outreach activities. CHWs typically belong to the same communities as the individuals they serve and are a provider type that may be beneficial in improving the quality and cultural responsiveness of care.[6] Similarly, CPRSs offer non-judgmental, practical information for individuals with OUD and provide unique insights through their lived experiences.[7,8] Evidence demonstrates that utilization of peer recovery specialists and other paraprofessionals is a promising practice for continued engagement among individuals with OUD.[9]

[5] If possible by the start of MOM enrollment in July 2021.
[6] American Public Health Association. Community Health Workers. (n.d.). Retrieved from: https://www.apha.org/apha-communities/member-sections/community-health-workers
[7] Certified Peer Recovery Specialists: https://bha.health.maryland.gov/Documents/CPRS%20Overview%20Guide_comms_030518.pdf
[8] Dardess, P., Dokken, D. L., Abraham, M. R., Johnson, B. H., Hoy, L., & Hoy, S. (2018). Partnering with patients and families to strengthen approaches to the opioid epidemic. Bethesda, MD: Institute for Patient- and Family-Centered Care.
[9] Ibid.

With regard to staffing ratios, the Improving Mood: Providing Access to Collaborative Treatment (IMPACT) model utilized one full-time case manager for a caseload of 100-120 participants. IMPACT case managers include clinical social workers, master's level counselors/therapists, nurses, and psychologists.[10] Another, the Mental Health Integration Program (MHIP) had a typical caseload of 50-75 participants per one full-time case manager; however, larger caseloads were managed with support from community health workers. MHIP targets mental health and substance use conditions, and case managers include social workers and nurses.[11] The Collaborative Care Model (CoCM) varies the caseload per each full-time case manager based on the target population characteristics. The CoCM has substantiated that a full-time case manager could have a lower caseload of 60-80 participants if they were Medicaid enrollees diagnosed with behavioral health conditions and had limited social supports. CoCM behavioral heath care managers include nurses, social workers, psychologists, and licensed counselors.[12,13]

MOM Model Provider Types and Staffing

Provider Types

The provider types (PT) that may provide case management and care coordination services in Maryland Medicaid for the MOM model are as follows: physician (PT 20), physician assistant (PT 80), nurse practitioner (PT 23), nurse midwife (PT 22), licensed clinical social worker (PT 94), psychologist (PT 15), certified professional counselor (PT CC), and psychiatric nurse (PT 24). Note that Maryland Medicaid does not currently reimburse for services rendered by certified peer recovery specialists (CPRS). An MCO could consider using CPRS and/or CHWs in their case management staffing model, which could be supported by the PMPM rate for enhanced case management activities, although secondary supports are not a requirement for the model.

Staffing Ratios

As described above, the Department identified several integrated health models to gain an understanding of an effective participant-to-case manager ratio. Findings from the review

[10] Unützer, J., Katon, W., Callahan, C., Williams, J., Hunkeler, E., Harpole, L., . . . Langston, C. (2002). Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. JAMA, 288(22), 2836-2845.
[11] Vannoy, S., Mauer, B., Kern, J., Girn, K., Ingoglia, C., Campbell, J., . . . Unützer, J. (2011). A Learning Collaborative of CMHCs and CHCs to Support Integration of Behavioral Health and General Medical Care. Psychiatric Services, 62(7), 753-758.
[12] AIMS Center. Guidelines on Caseload Size for Behavioral Health Care Managers and Psychiatric Consults. University of Washington: 2017. Retrieved from: http://aims.uw.edu/sites/default/files/Behavioral%20Health%20Care%20Manager%20Caseload%20Guidelines_072120%20Final.pdf
[13] AIMS Center. Behavioral Health Care Manager. Retrieved from: http://aims.uw.edu/collaborative-care/team-structure/care-manager

conducted determined that while ratios summarized for these cited models were higher than the Department's expectations for the MOM model, none of the models had the service delivery and care coordination activities that will be required for case managers to conduct on a monthly basis. Due to this, MCOs should consider substantially lower staffing ratios to accommodate the case management level forecasted to ensure success of the model. It should also be noted that case management activities that will be required and outlined in this document represent a bundle of enhanced services different from those already offered to pregnant and postpartum MCO participants.[14,15]

Bridging the gap between primary care, behavioral health treatment, obstetric care, and other social service needs requires a dedicated full-time case manager. Each MCO should employ or contract with qualified case managers to render the services described in this document. The number of case managers per MCO needed to implement the MOM model depends largely on the number of eligible participants within each MCO. The Maryland MOM model proposes having a ratio of one MCO case manager per 30 MOM model participants (1:30) due to the substantial amount of care coordination and associated tasks required by case managers to fulfill the requirements of the MOM model (outlined below) and to adequately address the myriad social and health needs for this vulnerable population.

Additionally, while MCOs are charged with providing the MOM model enhanced case management and care coordination services described in this document, MCOs may choose to partner with other entities, such as LHDs, to provide the MOM services on the MCOs' behalf.

Case Management Workflow - Associated Tasks and Timeline

MOM case managers will need to conduct certain tasks throughout a participant's engagement in the model and ensure the fulfillment of model requirements within a timely manner to receive PMPM payments.

It is imperative that case managers document all MOM related tasks within the MOM Care Coordination Module (CCM), hosted by CRISP, in addition to documentation that would normally occur separately within their EHR. Continually updating this information for all assigned MOM model participants within the MOM CCM, on at least a monthly basis, will be vital for MCOs to receive PMPM payments. Documentation within the MOM CCM will also play an essential role in the monitoring and evaluation components of the grant to measure the impact of model services, which is tied to the possibility of additional MOM milestone funding.

[14] COMAR 10.67.06.21: http://www.dsd.state.md.us/comar/comarhtml/10/10.67.06.21.htm
[15] COMAR 10.67.04.08: http://www.dsd.state.md.us/comar/comarhtml/10/10.67.04.08.htm

Successful completion of MOM interventions could result in incentives through this type of funding.

Please use this guide as a reference for associated tasks to be completed during the phases of participant engagement and the timeline to ensure compliance with the model. This document may be updated periodically with supplementary tasks (e.g. screening requirements) as needed, should CMMI request additional measures to be reported for grant monitoring and evaluation activities.

Pre-Enrollment: Referral Pathways and Eligibility Screening

- MCOs identify potentially eligible participants through the following avenues and forward referrals to case managers:
    - *No wrong door referral from other agencies: LHDs, LBHAs, law enforcement, EDs, somatic and BH providers, DHS*
    - Screening, Brief Intervention and Referral to Treatment (SBIRT)
    - Maryland Prenatal Risk Assessment (MPRA)
    - MCO data-mining and enrollment screening
    - Referral from the BH ASO
    - Referral from a community-services organization (CSO)
    - See also: Participant Engagement Strategies Brief
- Case managers receive referrals and contact identified potential participants to verify interest and confirm clinical eligibility
    - Current MD state resident residing in the MOM target area[16]
    - Current HealthChoice member
    - Currently pregnant (cannot enroll postpartum)
    - OUD Diagnosis - Must have a formal OUD diagnosis, at any point in participant's medical history, before the participant enrolls into the model. (See Appendix A for additional guidance.)
- Schedule an intake appointment (conducted in-person)[17]
    - Review approximate length of appointment and what to expect during session

Participants must be enrolled during pregnancy prior to delivery as one aspect of eligibility. As part of a strategy for identifying participants, a goal of the MOM model will be to increase both the amount of MPRAs completed by providers in a timely manner as well as streamline the

[16] St. Mary's County
[17] Subject to change

routing of MPRAs via ACCUs to MCOs to assist with identifying pregnant beneficiaries with OUD earlier in their pregnancy. Due to claims lag, the Department encourages MCOs to identify innovative ways other than data-mining to identify and recruit potentially-eligible participants on the front-end as part of their staffing plans for the MOM model. If data-mining is warranted, the following HCPCS codes are specifically related to prenatal care: H1000 and H1003. Please note the identification and use of these codes may not be a reliable method for identifying potentially-eligible participants in a timely manner and other approaches should be exhausted first.

To be considered eligible to participate in MOM model services, participants must have or receive an OUD diagnosis before enrolling into the MOM model. Appendix B outlines a list of ICD-9 and ICD-10-CM codes that constitute an OUD diagnosis for the purposes of the MOM model.

MCOs must engage with the BH ASO and check for Part 2 release of information (ROI) to assist in verifying a participant's clinical eligibility during the pre-enrollment screening process. If Part 2 ROI cannot be obtained in a timely manner and/or a potential participant does not have a claims history that indicates an OUD diagnosis, MCO CMs will be advised to assess for diagnostic criteria for OUD before enrolling into MOM model services. The verification of clinical eligibility should not delay enrollment into the MOM model if a participant self-attests to having a history of OUD and wishes to enroll to receive enhanced support during the pregnancy and postpartum periods. The Maryland MOM model serves as a protective factor during a time of heightened stress for individuals managing their OUD symptoms and other healthcare and social needs. (See Appendix A for additional clinical guidance.) Please refer to COMAR 10.67.08.02[18] for a list of procedure and diagnosis codes of non-capitated SUD covered services as well.

During Intake: First Month of MOM Participation

- Informed Consent
    - Explain program requirements and participant rights to voluntarily participate and withdraw, and answers any questions participants raise
    - Collect participant signature for informed consent and any other intake forms in addition to those required by the MOM model
- Initial Care Plan
    - Develop jointly during intake session
    - Confirm/collect participant contact information, denote preferred contact method, and emergency/secondary contacts

[18] http://www.dsd.state.md.us/comar/comarhtml/10/10.67.08.02.htm

    - Confirm/collect information on all providers participant is currently under the care of and their contact information
    - Identify 2-3 goals based on participant identified areas of need, to be reviewed during every monthly meeting and updated as needed
- Screenings that must be completed within 7 days of model enrollment (The Department recommends these be conducted during the initial intake visit, as all components are required to enroll participants into the model and results of these screenings may influence the care plan.) (See Appendices C and D for additional detail.)
    - *HRSN screening* – Administer MOM model adapted AHC screening tool located within CRISP.
    - *Depression screening* – captured through HRSN screening tool using the same screening and scoring methodologies as the PHQ-2; administer the PHQ-9 separately and create a follow-up plan for those who screen positive (score of 3 or above on PHQ-2 questions).
    - *Anxiety screening* – captured through separate GAD-7 screening, with indication of participant's level of anxiety documented.
    - *Tobacco screening* – captured through the HRSN screening tool; refer to tobacco cessation for those who screen positive.
    - *Alcohol screening* – captured through the HRSN screening tool.
    - *Patient Activation Measure (PAM) screening* – Entered into the Flourish tool administered by Insignia Health, document completion into care plan
- Care coordination activities
    - Provide referrals based on identified areas of need
    - Ensure needed medical appointments are made for the upcoming month, such as prenatal care visits and specialty behavioral health care visits
    - Coordinate care and establish and/or increase communication between/among participant's providers across systems of care, including with the BH ASO's care coordinators, as needed
- Documentation
    - Create new case in MOM CCM for the participant and populate.
    - Log into CRISP ULP and access the patient snapshot where participants' providers and clinical conditions are captured and add relevant information.
    - Indicate that informed consent has been signed in Care Coordination Module
    - Save a hard copy of the signed consent in a secure place
    - Document completed tasks into the module (consent, initial MOM care plan, screenings provided, contact information, care team, patient visit and contact type)
    - Document according to MCO's standards in their own hosted EHR

During Enrollment: Second month of MOM participation through 60 days postpartum

Participants will be engaged in MOM model services from the time of enrollment up to the infant's first birthday so long as the MOM model participant remains enrolled in Medicaid[19] and continues to meet the following requirements to be considered active.

Requirement 1: Monthly Case Management Visits and Model Requirements

On a monthly basis, MOM case managers will be expected to fulfill at least one of the five core components of the Maryland MOM model in, at a minimum, the following ways:

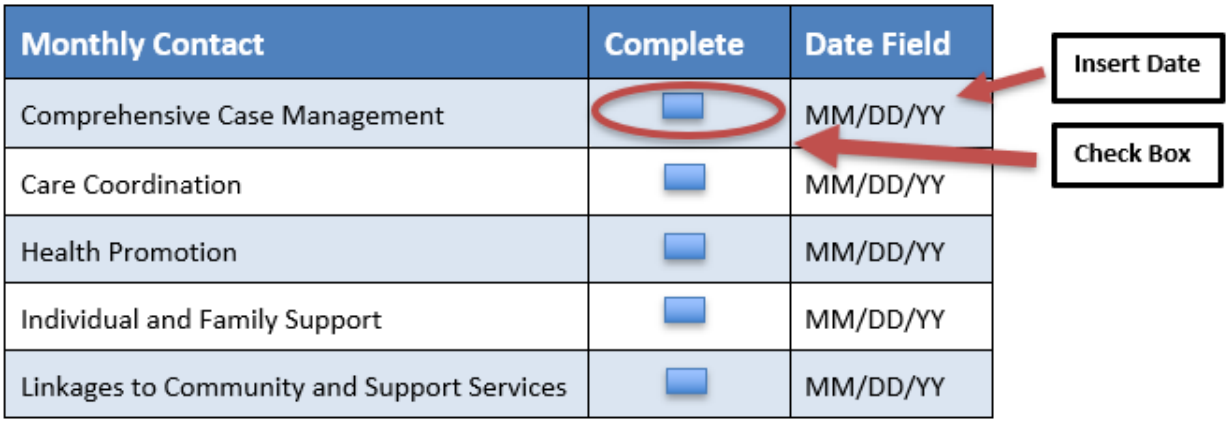
1. Comprehensive Case Management
    - Initial needs assessment and SDOH screening
    - Development and periodic reassessment of MOM care plan
    - Supportive shared decision-making process to understand and select from the landscape of health-related social needs resources
2. Care Coordination
    - Appropriate linkages to somatic and behavioral health providers as identified within care plan for the MOM model participant
    - Following up on needed services and supports
    - Serving as the established case manager for different providers and CSOs serving the MOM model participant
3. Health Promotion
    - Discussing recurrence of symptoms and creating a safety plan
        - Providing naloxone to the participant and educating friends/family on use of naloxone
    - Providing literature on Maryland Crisis Connect
        - Available 24/7 to people in need of crisis intervention, risk assessment for suicide, overdose prevention, support, guidance and information or linkage to community behavioral health providers
    - Discussing options for family planning
    - Nutritional counseling
    - Wellness programs
    - Education about STIs and other infectious diseases; e.g., viral hepatitis and HIV/AIDS Preventive healthcare education
    - Assisting with medication adherence
    - Educating family regarding appropriate infant developmental milestones and healthy attachment behaviors
4. Individual and Family Supports
    - With participant permission, involving partner and/or family in care activities
    - Training family about the role of recurrence of use and use of naloxone
    - Connecting families and children with needed supports such as parenting classes or family counseling

[19] Participants who do not remain income-eligible for Medicaid such as after 60 days postpartum or lose Medicaid coverage will no longer be eligible to participate in the MOM model.

5. Linkages to Community and Support Services
    - Connecting participants to resources related to the SDOH screening by completing warm handoffs with programs embedded in LHDs as well as LBHAs and CSOs, such as disability benefits, social services, SUD treatment, housing, legal services, life skills training and educational/vocational training and using CRISP's envisioned referral and community resources platform

The case manager will be responsible for fulfilling at least one of the five core components listed above at least once monthly. The case manager will then document which core component was completed in the Care Coordination Module under the 'Monthly Contact' tab by checking a box and inserting a date into the date field. This should be considered a minimum; MCO case managers are encouraged to provide as many of the five components on a monthly basis as are needed by the MOM model participant.

Figure 1. Monthly Contact in Care Coordination Module (Illustrative)



Requirement 2: Monthly Health Service Utilization

Case managers will need to ensure MOM model participants receive at least one behavioral health and/or somatic health visit each month in addition to conducting monthly case management contacts. Examples of behavioral health and somatic health visits are included in Table 1 below.

Table 1. Qualifying Monthly Visits, by Behavioral and Somatic Health Categories

Behavioral Health Visits	Somatic Health Visits
Alcohol and/or drug assessment	Primary Care
SBIRT	Specialty Care
Individual Therapy and/or Group Therapy	Federally qualified health center (FQHC) or other clinic services
Family psychotherapy and psychoeducation	Family Planning

Behavioral Health Visits	Somatic Health Visits
Medication Management	Dental services for pregnant individuals through date of delivery
Opioid maintenance therapy for individuals 18 years or over	Habilitation Services for Expansion Populations: (1) Physical therapy; (2) Occupation therapy; and (3) Speech therapy
Intensive Outpatient (ASAM Level 2.1)	OB/GYN Care- Prenatal, perinatal, and postpartum care visits
Partial Hospitalization (ASAM Level 2.5)	Labor and Delivery services
Ambulatory Detox	Newborn Care and Well Child visits

Please note that provision of MOUD does not qualify as a behavioral health visit under the MOM model.

Periodic Re-assessments of Screenings and Care Plan

To identify early recurrence of use and prevent fatal overdose, MOM case managers will screen participants for both postpartum depression as well as SUD. Please refer to Appendix C for the frequency of re-assessments for each screening.

Documentation

- Document completed tasks into the module (re-assessment of participant goals and indicated barriers, screenings provided (including an indication substance use screening was administered postpartum), contact information, care team, patient visit and contact type)
- Document model core elements provided during visits including health promotion activities surrounding screening for SUD and naloxone distribution provided after delivery
- Document any contact attempts and type of outreach made when participant misses appointments and case management visits
- For MOM model participants losing Medicaid coverage at 60 days postpartum: Assess for outstanding needs, provide referrals to on-going services, as needed, change MOM model enrollment status into the module and submit a care alert indicating the participant is no longer active

During Enrollment: 60 days postpartum through infant's first birthday

To meet requirements stipulated by CMMI, MOM model participants who lose Medicaid eligibility will no longer be eligible for services, even if their infant remains enrolled in Medicaid. MOM model case managers are encouraged to work with those at risk of losing Medicaid coverage at 60 days postpartum to seek alternative health coverage, such as subsidized health plans available through the Maryland Health Benefit Exchange. For MOM model participants

that do not lose Medicaid eligibility after two-months postpartum, enhanced MOM model case management services will continue until the infant's first birthday.

Monthly CM Visits and Model Requirements

- Case Managers will still need to ensure they are providing monthly Case Management visits and fulfilling at least one of the five core elements for the remainder of the participant's time in the MOM model. Case managers will need to ensure MOM model participants receive a minimum of one behavioral health or somatic health visit each month in addition to conducting monthly case management contacts.

Re-assessments of Screenings and Care Plan

- Care Plan – Re-assess participants needs and goals and revisit care plan on a monthly basis and update goals as needed
- HRSN Tool – Re-administer screening after 60 days postpartum every three months or as needed. Administered a final time during the last month of a participant's enrollment

Documentation

- Document tasks into the MOM CCM (consent, re-assessment of participant goals and indicated barriers, screenings provided, contact information, care team, patient visit and contact type)
- Document model core elements provided during visits
- Document any contact attempts and type of outreach made when participant misses appointments and CM visits

Disengaged Participants and Outreach Process

Maximum of two months if MOM model participants are lost to follow-up

Substantial outreach is a specific protocol for re-engaging MOM model participants case managers will follow in the event that MOM model participants become disengaged from care (e.g. miss a doctor's appointment or miss a monthly MCO case manager contact). With documentation logging the date and type of each contact attempt described in additional detail below, MCOs will receive a PMPM payment for providing substantial outreach for disengaged beneficiaries for up to two months. There are a variety of loss-to-follow-up activities that the Department will accept to continue the PMPM payment.

Case managers will need to follow outreach guidelines for enrolled participants when they first become disengaged from services. Before transitioning a participant to the substantial outreach phase of participation, case managers will need to make three contact attempts, to be logged in CRISP-based care coordination module:

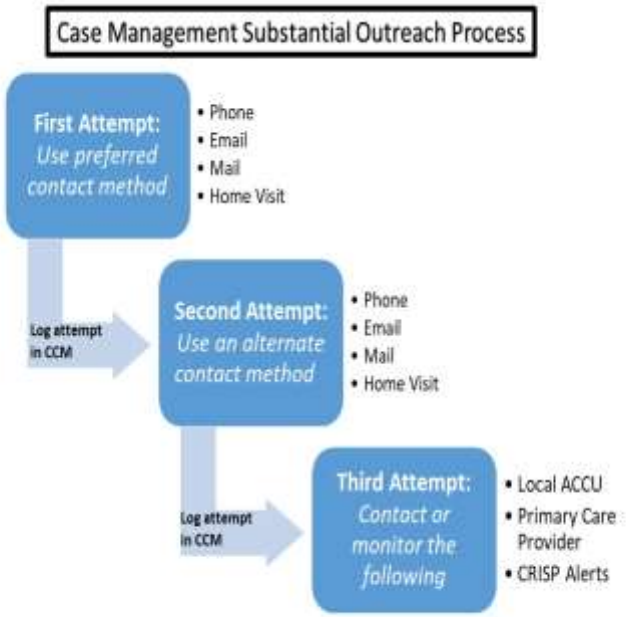
- First attempt using preferred method of contact as identified in the Maryland Health Connection
- Others may include phone, email, mail, and home drop by visits

If participants can still not be re-engaged after following the above procedures, they will be considered lost to follow-up and provided two months' worth of substantial outreach. Potential outreach strategies may include the following:

- Use Healthy Families American and Nurse-Family Partnership protocols;
- Contacting participants' family members, friends, partners, and emergency contacts via phone multiple times at different times of day;
- Sending mail correspondence to the participant's home or listed addresses;
- Deploying assigned MOM case manager or other assigned care plan team members (i.e. CPRS and/or CHWs) to the participant's home and/or community, including on evenings or weekends;
- Contacting participant's primary care provider and other providers to assist with reengagement;
- Connecting with local ACCUs or other connected departments and community programs participant is involved with (i.e. DPSCS; DHS);
- Monitoring CRISP hospital utilization alerts to check inpatient admissions and emergency encounters; and
- Log three attempts at minimum per month into the care coordination module. The three attempts should be at least two different types of follow-up, such as two phone calls and one letter in the mail. The third attempt could also involve other systems as demonstrated in the following visual.
- See also: Participant Engagement Strategies Brief

To qualify for a PMPM payment, substantial outreach activities must be conducted and documented during each month, for a maximum of two consecutive months.

Figure 2. Case Management Substantial Outreach Process by Mont



Discharge Planning

Last month before infant's first birthday or at case closure[20]

- Conduct final case management visit, providing at least one core model component
    - Linkages (wrapping up connecting MOM model participant to social needs)
    - Health promotion (*e.g.,* providing naloxone; family planning materials)
    - Care coordination and warm handoffs
- Assess outstanding needs
    - Review Care Plan developed goals, determine areas that may need continued support and provide a discharge plan to participant upon the end of services
    - Final HRSN screening and referrals
    - Anxiety screening – if needed
    - Depression screening – Provide linkages to on-going supports if positive screening
- Documentation
    - Document all tasks and relevant screenings into the MOM CCM
    - Indicate status of MOM enrollment and notate if participant was discharged due to loss to follow-up or if they completed services

[20] Discharge planning activities do not need to be completed if a MOM model participant is being discharged due to reasons other than completing services such as loss to follow-up. Ensure all outreach attempts are logged into the module and follow only the documentation section in these instances.

- Submit care alert indicating participant is no longer active

Appendix A: OUD Diagnosis Criteria for Self-Report of History with OUD

DSM-V Criteria for Diagnosis of Opioid Use Disorder[21]

Diagnostic Criteria A. A problematic pattern of opioid use leading to clinically significant impairment or distress as manifested by at least two of the following, occurring within a 12 month period:	
Check all that apply	
	Opioids are often taken in larger amounts or over a longer period of time than intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
	Craving, or a strong desire to use opioids.
	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous.
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

Total Number of Boxes Checked: _____

Severity:

[21] Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association page 541.

- **Mild:** 2-3 symptoms
- **Moderate:** 4-5 symptoms
- **Severe:** 6 or more symptoms

Specify if:

In early remission: After full criteria for OUD were previously met, none of the criteria for OUD have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, “Craving, or a strong desire or urge to use opioids,” may be met).

In sustained remission: After full criteria for OUD were previously met, none of the criteria for OUD have been met for at any time during a period of 12 months or longer (with the exception that Criterion A4, “Craving, or a strong desire or urge to use opioids,” may be met).

Appendix B. OUD ICD-9 and ICD-10 Diagnosis Codes and Description

Code and Description	
ICD-9-CM codes	**Description**
30400	Opioid type dependence, unspecified
30401	Opioid type dependence, continuous
30402	Opioid type dependence, episodic
30403	Opioid type dependence, in remission
30470	Combinations of opioid type drug with any other drug dependence, unspecified
30471	Combinations of opioid type drug with any other drug dependence, continuous
30472	Combinations of opioid type drug with any other drug dependence, episodic
30473	Combinations of opioid type drug with any other drug dependence, in remission
30550	Opioid abuse, unspecified
30551	Opioid abuse, continuous
30552	Opioid abuse, episodic
ICD-10-CM codes	**Description**
F111	Opioid abuse
F1110	Opioid abuse, uncomplicated
F1112	Opioid abuse with intoxication
F112	Opioid dependence
F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F1122	Opioid dependence with intoxication
F1123	Opioid dependence with withdrawal
F1124	Opioid dependence with opioid-induced mood Disorder
F1128	Opioid dependence with other opioid-induced disorder
F1129	Opioid dependence with unspecified opioid-induced disorder
F1190	Opioid use, unspecified, uncomplicated
F11921	Opioid use, unspecified, with intoxication Delirium
F1194	Opioid use, unspecified with opioid-induced mood disorder
F1199	Opioid use, unspecified with unspecified opioid-induced disorder
F11120	Opioid abuse with intoxication, uncomplicated
F11121	Opioid abuse with intoxication delirium
F11122	Opioid abuse with intoxication with perceptual disturbance

Code and Description	
ICD-9-CM codes	**Description**
F11129	Opioid abuse with intoxication, unspecified
F1114	Opioid abuse with opioid-induced mood disorder
F1115	Opioid abuse with opioid-induced psychotic disorder
F11150	Opioid abuse with opioid-induced psychotic disorder with delusions
F11151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
F11159	Opioid abuse with opioid-induced psychotic disorder, unspecified
F1118	Opioid abuse with other opioid-induced disorder
F11181	Opioid abuse with opioid-induced sexual dysfunction
F11182	Opioid abuse with opioid-induced sleep disorder
F11188	Opioid abuse with other opioid-induced disorder
F1119	Opioid abuse with unspecified opioid-induced disorder
F11220	Opioid dependence with intoxication, uncomplicated
F11221	Opioid dependence with intoxication delirium
F11222	Opioid dependence with intoxication with perceptual disturbance
F11229	Opioid dependence with intoxication, unspecified
F1125	Opioid dependence with opioid-induced psychotic disorder
F11250	Opioid dependence with opioid-induced psychotic disorder with delusions
F11251	Opioid dependence with opioid-induced psychotic disorder with hallucinations
F11259	Opioid dependence with opioid-induced psychotic disorder, unspecified
F11281	Opioid dependence with opioid-induced sexual dysfunction
F11282	Opioid dependence with opioid-induced sleep disorder
F11288	Opioid dependence with other opioid-induced disorder
F119	Opioid use, unspecified
F1192	Opioid use, unspecified with intoxication
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11922	Opioid use, unspecified with intoxication with perceptual disturbance
F11929	Opioid use, unspecified with intoxication, unspecified
F1193	Opioid use, unspecified with withdrawal
F1195	Opioid use, unspecified with opioid-induced psychotic disorder
F11950	Opioid use, unspecified with opioid-induced psychotic disorder with delusions
F11951	Opioid use, unspecified with opioid-induced psychotic disorder with hallucinations
F11959	Opioid use, unspecified with opioid-induced psychotic disorder, unspecified
F1198	Opioid use, unspecified with other specified opioid-induced disorder

Code and Description	
ICD-9-CM codes	**Description**
F11981	Opioid use, unspecified with opioid-induced sexual dysfunction
F11982	Opioid use, unspecified with opioid-induced sleep disorder
F11988	Opioid use, unspecified with other opioid-induced disorder

Appendix C. Screenings Frequency and Approach

Table C1. Overview

	Approach	Intake	90 Days	Third Trimester	Postpartum
HRSN	Modified AHC tool	X		X	X
Depression	Embedded in HRSN, with additional requirements in the case of a positive result	X		X	X
Anxiety	GAD-7	X			X
Tobacco	Embedded in HRSN	X		X	X
Alcohol	Embedded in HRSN	X		X	X
PAM	Flourish tool	X	X		
SUD	NIDA-Modified ASSIST				X

Health-Related Social Needs (HRSN)

Administer modified Accountable Health Communities HRSN Tool accessed via CRISP.

***Timing*:** Administered within 7 days of model enrollment, a second time during the participant's third trimester, then a third time after the end of pregnancy within 60 days postpartum. Subsequent screenings administered every three months or as needed for participants who continue to be enrolled in Medicaid.

Depression

Captured through HRSN screening tool using the same screening and scoring methodologies as the PHQ-2; for those who screen positive (score of 3 or above on PHQ-2 questions) administer the remaining 7 questions of the PHQ-9 (separately) and create a follow-up plan.

***Timing*:** Administered as part of the HRSN tool within 7 days of model enrollment, during the third trimester, and at the end of pregnancy within 60 days postpartum. Subsequent screenings administered as needed as part of the HRSN screening cadence for participants who continue to be enrolled in Medicaid. Repeat the same procedure in deploying the PHQ-9 screening if a participant screens positive and create a follow-up plan for those participants.

Anxiety

Captured through GAD-7 screening, with indication of participant's level of anxiety documented.

***Timing*:** Administered at a minimum within 7 days of model enrollment and after the end of pregnancy within 60 days postpartum. Subsequent screenings administered as needed for participants who continue to be enrolled in Medicaid.

Tobacco

Capture through HRSN screening tool; added questions inquiring into the number of cigarettes smoked, in the case of a positive result. Refer to tobacco cessation for those who screen positive.

***Timing*:** For beneficiaries who enroll in the MOM Model during their first or second trimester, it is recommended an additional tobacco screening be completed during the third trimester. In total, these beneficiaries should receive at least three screenings: within 7 days of Model enrollment, during the third trimester, and within 60 days after the end of pregnancy. Subsequent screenings administered as needed as part of the HRSN screening cadence for participants who continue to be enrolled in Medicaid.

Alcohol

Capture through HRSN screening tool.

***Timing*:** Administered at a minimum within 7 days of model enrollment, during the participant's third trimester, and after the end of pregnancy within 60 days postpartum. Subsequent screenings administered as needed as part of the HRSN screening cadence for participants who continue to be enrolled in Medicaid.

Patient Activation Measure

Enter directly into the Flourish tool administered by Insignia Health, document completion into Care Coordination Module.

***Timing*:** Administered within 7 days of model enrollment and a follow-up at least 90 days from initial assessment.

SUD (NIDA-Modified ASSIST)

Administered through the NIDA-Modified ASSIST screening tool, document completion and any interventions offered as a result of participant's score into Care Coordination Module.

***Timing*:** Administered once within 60 days after the end of pregnancy.

Appendix D: Health-Related Social Needs, Depression, Anxiety, and SUD Screenings

Health-Related Social Needs

(Accessed via CRISP)

Question	Response
Domain: Living Situation	
What is your living situation today?	I have a steady place to live
	I have a place to live today, but I am worried about losing it in the future
	I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY	Pests such as bugs, ants, or mice
	Mold
	Lead paint or pipes
	Lack of heat
	Oven or stove not working
	Smoke detectors missing or not working
	Water leaks
	None of the above
Domain: Food	
Some people have made the following statements about their food situation. Please answer whether these statements were OFTEN, SOMETIMES OR NEVER true for you and your household in the last 12 months. Within the past 12 months, you worried that your food would run out before you got money to buy more.	Often true
	Sometimes true
	Never true
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.	Often true
	Sometimes true
	Never true
Domain: Transportation	

Question	Response
In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting to things needed for daily living?	Yes
	No
Domain: Utilities	
In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?	Yes
	No
	Already shut off
Domain: Safety ** A score of 11 or more when the numerical values for answers to the following questions posed in this domain are added indicates a positive result that the person might not be safe.*	
Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions. How often does anyone, including family and friends, physically hurt you?	Never (1)
	Rarely (2)
	Sometimes (3)
	Fairly often (4)
	Frequently (5)
How often does anyone, including family and friends, insult or talk down to you?	Never (1)
	Rarely (2)
	Sometimes (3)
	Fairly often (4)
	Frequently (5)
How often does anyone, including family and friends, threaten you with harm?	Never (1)
	Rarely (2)
	Sometimes (3)
	Fairly often (4)
	Frequently (5)
How often does anyone, including family and friends, scream or curse at you?	Never (1)
	Rarely (2)
	Sometimes (3)
	Fairly often (4)
	Frequently (5)

Question	Response
Domain: Financial Strain	
How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is…	Very hard
	Somewhat hard
	Not hard at all
Domain: Employment	
Do you want help finding or keeping work or a job?	Yes, help finding work
	Yes, help keeping work
	I do not need or want help
Domain: Education	
Do you speak a language other than English at home?	Yes
	No
Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent.	Yes
	No
Domain: Substance Use ** Additional questions may be added pending CMMI requirements and other new data elements. Please refer separately to SUD screening during the postpartum period to monitor for risk and provide health education.*	
During the last month, how many alcoholic drinks did you have in an average week? A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.	I Didn't Drink in the Last Month
	Less than 1 Drink a Week
	1 to 3 Drinks a Week
	4 to 7 Drinks a Week
	8 to 13 Drinks a Week
	14 Drinks or More a Week
	Did Not Answer/Unknown
How many times in the past 12 months have you used tobacco products (not including electronic cigarettes)?	Never
	Once or twice
	Monthly

Question	Response
	Weekly
	Daily or almost daily
On average, how many cigarettes do you smoke per day?	(free text)
Domain: Mental Health ** Note: The AHC mental health questions are equivalent to the PHQ-2 depression screening. To meet the MOM depression screening requirement, if a MOM participant initially screens positive (3 or above on the first two questions posed in this section), MOM case managers will conduct the full PHQ-9 with the participant. After completing this section, please administer and score the GAD-7 separately.*	
Over the past 2 weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things?	Not at all (0)
	Several days (1)
	More than half the days (2)
	Nearly every day (3)
Feeling down, depressed, or hopeless?	Not at all (0)
	Several days (1)
	More than half the days (2)
	Nearly every day (3)
Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. Do you feel this kind of stress these days?	Not at all
	A little bit
	Somewhat
	Quite a bit
	Very much
Domain: Family and Community Support	
If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?	I don't need any help
	I get all the help I need
	I could use a little more help
	I need a lot more help

Question	Response
How often do you feel lonely or isolated from those around you?	Never
	Rarely
	Sometimes
	Often
	Always
Domain: Maternal Child Health	
Who can you count on for help/support during this pregnancy?	(Free text)
Who can you talk to about stressful things in your life?	(Free text)
Do you need daycare for your child?	Yes
	No
If yes, would you like help finding it?	Yes
	No
	Maybe later

Depression

To be administered in the case of a positive PHQ-2 result (score of 3 or more) during HRSN

PHQ-9 Screening[22]

Over the last 2 weeks, how often have you been bothered by any of the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total score: 1-4 minimal depression; 5-9 mild depression; 10-14 moderate depression; 15-19 moderately severe depression; 20-27 severe depression

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Anxiety

GAD-7 Screening[23]

Over the last 2 weeks, how often have you been bothered by the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

Total score: 0-5 mild anxiety; 6-10 moderate anxiety; 11-15 moderately severe anxiety; 15-21 severe anxiety

[23] Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166:1092-7.

Substance Use Disorder

NIDA-Modified ASSIST V2.0[24]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

[24] The NIDA Quick Screen was adapted from a single-question screen for drug use in primary care by Smith et al. 2010 and the National Institute on Alcohol Abuse and Alcoholism's Helping Patients Who Drink Too Much: A Clinician's Guide Updated 2005 Edition. The NIDA-Modified ASSIST (NM ASSIST) was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST).

- If the patient indicates that the drug used is not listed, please mark **'Yes'** next to 'Other' and continue to **Question 2** of the NIDA-Modified ASSIST**.** If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Question 2 of 8, NIDA-Modified ASSIST 2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

- For patients who report **"Never"** having used any drug in the past 3 months: **Go to Questions 6-8**.
- For any recent **illicit or nonmedical prescription drug use**, go to **Question 3.**

3. In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6

f.	**Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)**	0	3	4	5	6
g.	**Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)**	0	3	4	5	6
h.	**Street Opioids (heroin, opium, etc.)**	0	3	4	5	6
i.	**Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)**	0	3	4	5	6
j.	**Other – Specify:**	0	3	4	5	6

4. During the past 3 months, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 6 & 7 for all substances **ever used** (i.e., those endorsed in the Question 1).

6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

Substance Involvement Score	Total (SI SCORE)
Cannabis (marijuana, pot, grass, hash, etc.)	
Cocaine (coke, crack, etc.)	
Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
Methamphetamine (speed, crystal meth, ice, etc.)	
Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
Street Opioids (heroin, opium, etc.)	
Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
Other – Specify:	

To determine patient's risk level based on his or her SI Score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk